From: Scott Chad D
To: Norman Chris P; Oyster Michael W; CORBIN Nicole
Cc: Busek Rhonda J
Subject: RE: Fality Criteria
Date: Thursday, November 2, 2017 4:21:00 PM
Attachments: image001.png
image002.jpg
image003.jpg

Yes, we should meet. The topic of where will people go and who will help them? Was a discussion topic during the ORPA meeting today.

From: Norman Chris P
Sent: Thursday, November 02, 2017 3:52 PM
To: Scott Chad D ; Oyster Michael W ; CORBIN Nicole
Cc: Busek Rhonda J
Subject: RE: Fality Criteria

Hi Chad,

I think this might be a good topic for a meeting – Chad, are you thinking this needs to happen this week?

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From: Scott Chad D
Sent: Friday, October 27, 2017 8:34 AM
To: Oyster Michael W <MICHAEL.W.OYSTER@dhsoha.state.or.us>; CORBIN Nicole <Nicole.CORBIN@dhsoha.state.or.us>; Norman Chris P <CHRIS.P.NORMAN@dhsoha.state.or.us>
Cc: Busek Rhonda J <RHONDA.J.BUSEK@dhsoha.state.or.us>
Subject: RE: Fality Criteria

Happy Friday!

I'm concerned with the overt focus by Choice contractors (FamilyCare last week and Multnomah County this week) on OHA's responsibility to assure decisions made by Kepro are appropriate, supported and legal. Analysis or determination of OHA's compliance with program rules is not a contracted function of Choice contractors.

I would like to see this discussion focused on what policies or processes have been developed and have been implemented by Choice contractors to assure members have access to all Medicaid and non-Medicaid service and support

options they are entitled. I would also like some assurance Choice contractors are aligned with OHA and Kepro as our system works toward meeting the outcomes required by USDOJ in the Oregon performance plan.

We are at the point in our work where a significant number of members will need to receive services in a setting other than licensed residential. Based on the recent statements from Choice contractors, I don't think they are in alignment with OHA's goals, may not be prepared to meet the needs of members ready to transition and may actually be working against OHA by questioning our compliance and process, maybe even providing legal advice to members, guardians and providers to question Kepro's determinations. I'm concerned they might provide inaccurate information based on role confusion and that could result in OHA having to hold hearings for members who may not have otherwise requested one without advisement from a Choice contractor. I'd like your thoughts on this. Is there something we can do to refocus their attention back to their scope of work? Can we request they provide a readiness plan or something to demonstrate they can meet their requirements in their contract?

I also suggest we provide clarification to the Choice contractors around their role. Maybe make some of the following points;

- The setting (place of service) or provider type (license type) are not a Medicaid benefit. Individuals in OHA licensed programs are receiving habilitation or personal care, they aren't receiving "Adult Foster Care" or "Secure Residential Treatment".
- Kepro is reviewing for the medical appropriateness of the Medicaid benefits of mental health rehabilitation, habilitation or personal care services as defined in administrative rule.
- The majority of continued stay denials are generally not a denial of benefit or determination the person does not need a service, rather, these are determination the person can receive the services in a more integrated community setting. That setting is based on member choice and the extent to which it is determined a person cannot receive medically appropriate services without the supports of a licensed setting.
- It is up to the provider of services to justify to a payer why their provider type or specialty is the most appropriate choice for delivery of a service to a Medicaid member. It is Kepro' s role to review and make

determination of provider payment requests.

- When approving a service, the most integrated community service delivery option must always be considered primary. OHA and its designee may also consider services of least cost and outcomes in this decision making process.
- Choice contractors are not providers or payers of Medicaid benefits and are not contracted as an EQRO by OHA.
- Choice contractors are contracted to provide service coordination for Medicaid and non-Medicaid services and supports. Within that scope of work, Choice contractors must consider member choice and the availability of other provider types and places of service as options for members to receive services to meet their assessed need or treat their condition.

Shannon will be sending the list to date of members determined ready for transition from residential with Choice contractor specific information.

Thanks

From: Debra Brooks [mailto:dbrooks@kepro.com]
Sent: Thursday, October 26, 2017 5:23 PM
To: Lisa LOEWENTHAL <lisa.loewenthal@multco.us>; Hannah Earley <hearley@kepro.com>
Cc: Rajeev Mudumba <rmudumba@kepro.com>; Scott Chad D <CHAD.D.SCOTT@dhsoha.state.or.us>; Oyster Michael W <MICHAEL.W.OYSTER@dhsoha.state.or.us>
Subject: RE: Facility Criteria

Hi Lisa,

I'll jump in here – hopefully I can be helpful.

You are absolutely right, Lisa, the OAR's are broad and imprecise, that is the way they were written. Kepro cannot change that.

In order to qualify for residential treatment paid for by Medicaid, the member has to have symptoms that correspond with a severe mental illness and be able to benefit from the proposed treatment plan. The end goal is to be able to successfully reintegrate into an independent community-based living arrangement.

There are several tools that can be used to help support these cases. (We provided several of these tools when we met a few weeks ago). Of course, the best way to determine level of care is for us to interview the member, which we are working hard to accomplish.

Please feel free to call us if you have individual case.

Take care,

Deb

Debra Brooks, LCSW
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From: Lisa LOEWENTHAL [mailto:lisa.loewenthal@multco.us]
Sent: Thursday, October 26, 2017 3:52 PM
To: Hannah Earley <hearley@kepro.com>
Cc: Rajeev Mudumba <rmudumba@kepro.com>; Debra Brooks <dbrooks@kepro.com>; Scott Chad D <CHAD.D.SCOTT@dhsoha.state.or.us>
Subject: Re: Facility Criteria

Hi,
Thanks for the e-mail. For clarification, utilization management when noting medical necessity, unpack it to show what meets medical necessity for different levels.
So, it would be helpful for the criteria, to be able to see what the medical necessity is for each one: RTF, RTH and AFC. Just noting that medical necessity needs to be met seems to be too broad and not precise.
Thanks,
Lisa

On Thu, Oct 26, 2017 at 3:47 PM, Hannah Earley <hearley@kepro.com> wrote:

> Click With Caution -
>
> 
>
> Greetings Lisa,
> We wanted to get back to you regarding your question about the criteria we use for determining authorizations for RTF/RTH and AFH levels of care. We use the criteria set out in the OARs, mostly OAR 410-172-0720 which outlines rules for "Prior Authorization and Re-Authorization for Residential Treatment." While the OAR 410-172-0720 title says "residential treatment," the AFH guidelines state this OAR should be referenced for AFHs also (see page 1 and 7 of the AFH guidelines).
> Lines 2, 3, 11 and 12 of OAR 410-172-0720 are a good point of reference for what we are looking for:
> *(2) Residential treatment is intended as an outcome-based, transitional, and episodic period of care to provide service and supports in a structured environment that will allow the individual to successfully reintegrate into an independent community-based living*

arrangement.
(3) Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environment in the community.
(11) The Division shall determine re-authorization and authorization of continued stays based upon one of the following:

- *The recipient continues to meet all basic elements of medical appropriateness and;*

- *One of the following criteria shall be met:*

    - *Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;*

    - *The recipient has developed new or worsening symptoms or behaviors that require continued stay in the current level of care;*

(12) Requests for continued stay based on these criteria shall include documentation of ongoing re-assessment and necessary modification to the current treatment plan or residential plan of care.
The main question we ask as we take these OARs into consideration is “What mental health symptoms does this client have that currently prevent them from living at a lower level of care?”
If providers and ENCCs have any questions, the best thing to do is to call us for support. Also, please don’t hesitate to pass this along to anyone who has similar questions.
Thank you for asking!
Best,
Hannah
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Hi Hannah,
Thank you so much for attending our provider meeting. I appreciate that you and Debra answered everyone's questions, even when they were coming thick and fast.
I wonder if you could e-mail me the SRTF criteria form so I can share it with the meeting participants, as several people requested it. Also, would be you able to send me the criteria for the other levels of care as soon as those are available?
Thanks so much,
Lisa
--

Lisa Loewenthal, LCSW
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Multnomah County Health Department
Phone: 503-988-8197
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My gender pronouns are they, them and theirs.

Please remember to always use encryption with protected health information.

--

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